

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01317

CERTIFICATE OF DEATH

01279

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CALIFORNIA		c. LENGTH OF STAY IN b. LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SUSIE CATHERINE ARMSWORTHY		First MIDDLE Last	4. DATE OF DEATH Month JANUARY 12, 1966
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. NEVER MARRIED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME THOMAS THEODORE HAYDEN		14. MOTHER'S MAIDEN NAME EMMA TIPPETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 17. INFORMANT WILLIAM I. ARMSWORTHY CALIFORNIA MARYLAND	
Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 1960 , to Jan 12, 1966 , that (I) (we) last saw the deceased alive on Jan 12 1966 , and that death occurred at 9:40 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>P. J. BEAN M. D.</i>		ATTENDING MD. PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 1/19/66
22c. PHYSICIAN'S NAME (Type) P. J. BEAN M. D.		22d. ADDRESS GREAT MILLS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 15, 1966	23c. NAME OF CEMETERY OR CREMATORIAL HOLY FACE CEMETERY
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		ADDRESS	25a. REC'D BY REGISTRAR JAN 19 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01318

CERTIFICATE OF DEATH

01280

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on the day of death.

1. PLACE OF DEATH o. COUNTY ST. MARY'S		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND		b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN lb LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		d. STREET ADDRESS MECHANICSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First ELEANOR	Middle BUCKLER	Lost	4. DATE OF DEATH JANUARY 8, 1966	Month JANUARY	Doy 8	Year 1966	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 19, 1878	9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME THOMAS L. GRAVES				14. MOTHER'S MAIDEN NAME DORCILLA VICTORIA BUCKLER		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT					
				MRS XAVIER WOOD		MECHANICSVILLE, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardiovascular - renal failure INTERVAL BETWEEN ONSET AND DEATH 3 mos									
4221 DUE TO									
(b) Atherosclerotic cv disease 25 yrs									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jan		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 50 , to Jan 8 , 19 66 , that (I) (we) last saw the deceased alive on Jan 4 , 19 66 , and that death occurred at 7:00 AM from causes and on the date stated above.									
22a. SIGNATURE Ray Guyther		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. Ray Guyther M.D.		22d. ADDRESS		MECHANICSVILLE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 11, 1966		23c. NAME OF CEMETERY OR CREMATORIAL MT. ZION		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
				LAUREL GROVE, MARYLAND		J. Charles Judge			
				DATE JAN 13 1966					

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01319

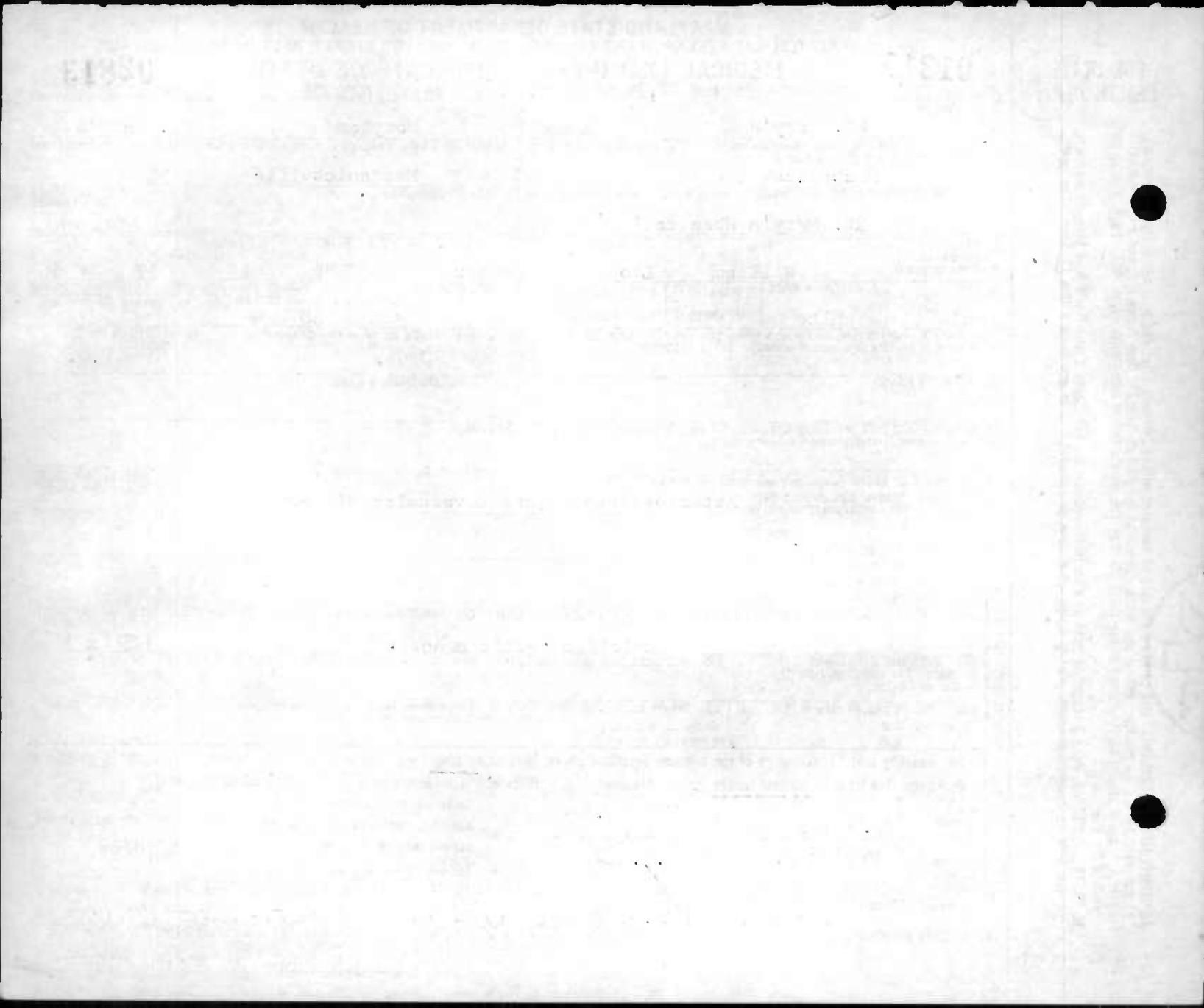
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02813

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT.		2		TO DEPUTY MEDICAL EXAMINER	
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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01320

CERTIFICATE OF DEATH

02815

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 20 DAYS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) DOROTHY PERKINS GODFREY		First DOROTHY	Middle PERKINS			
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH SEPT. 30, 1882			
10. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) Victorian (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Food	9. AGE (In years lost birthday) 83 yrs.			
13. FATHER'S NAME HOBACE A. GODFREY		11. BIRTHPLACE (County & State, or foreign country) NEW HAMPSHIRE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 125-18-0521	17. INFORMANT HOSPITAL RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Circulatory & Myocardial Failure DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) Bronchopneumonia DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH Wks						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atherosclerotic Cardio-vascular Disease						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) GREAT MILLS	(County) MARYLAND	(State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 1965 to 1/31, 1966 , that (I) (we) last saw the deceased alive on 1/30, 1966 and that death occurred at 114 M. from causes and on the date stated above.						
22a. SIGNATURE James P. Jarboe		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1/31/66			
22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M. D.		22d. ADDRESS GREAT MILLS, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 1/31/66	23c. NAME OF CEMETERY OR CREMATORIAL FORT WILSON CEMETERY	23d. LOCATION (City or Town) (County) (State) COLUMBIA MARYLAND, MARYLAND		
24. FUNERAL DIRECTOR W.W. CHAMBERS L.L.C. WASH. D.C.		ADDRESS		25a. REC'D BY REGISTRAR FEB 8 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 20 M 1/66		DATE				

This certificate sent in written in red. These items are not
corrections

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

01321

CERTIFICATE OF DEATH

01281

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harry	Middle Cornelius	Last Graves		
4. DATE OF DEATH	Month January	Day 3	Year 1966		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 25 1898		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Operator		10b. KIND OF BUSINESS OR INDUSTRY Hotel	11. BIRTHPLACE (County & State, or foreign country) Colorado		
13. FATHER'S NAME Henry Graves		14. MOTHER'S MAIDEN NAME Mary Greene			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 578-46-9566	17. INFORMANT Address Mrs. Mildred Graves (Wife) Colton's Point, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Causing after</i> (c) <i>relief</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12-31 , 19 66 , to 1-3-66 , 19 66 , that (I) (he) last saw the deceased alive on 12-66 , 19 66 , and that death occurred at Colton's Point , M, from the causes and on the date stated above.		22b. DATE SIGNED 1-5-66			
22a. SIGNATURE <i>Michael Barbarich</i>		22b. ADDRESS Leonardtown, Maryland			
22c. PHYSICIAN'S NAME (Type) Michael Barbarich M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JAN. 6, 1966	23c. NAME OF CEMETERY OR CREMATORIAL LINCOLN MEMORIAL CEMETERY SUITLAND, MARYLAND	23d. LOCATION (City, town or county) (State) SUITLAND, MARYLAND
24. FUNERAL DIRECTOR Mattingly's		ADDRESS Leonardtown, Md.		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE CHARLES JUDGE
VR A15 (4) 15M 4-64		DATE JAN 13 1966			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

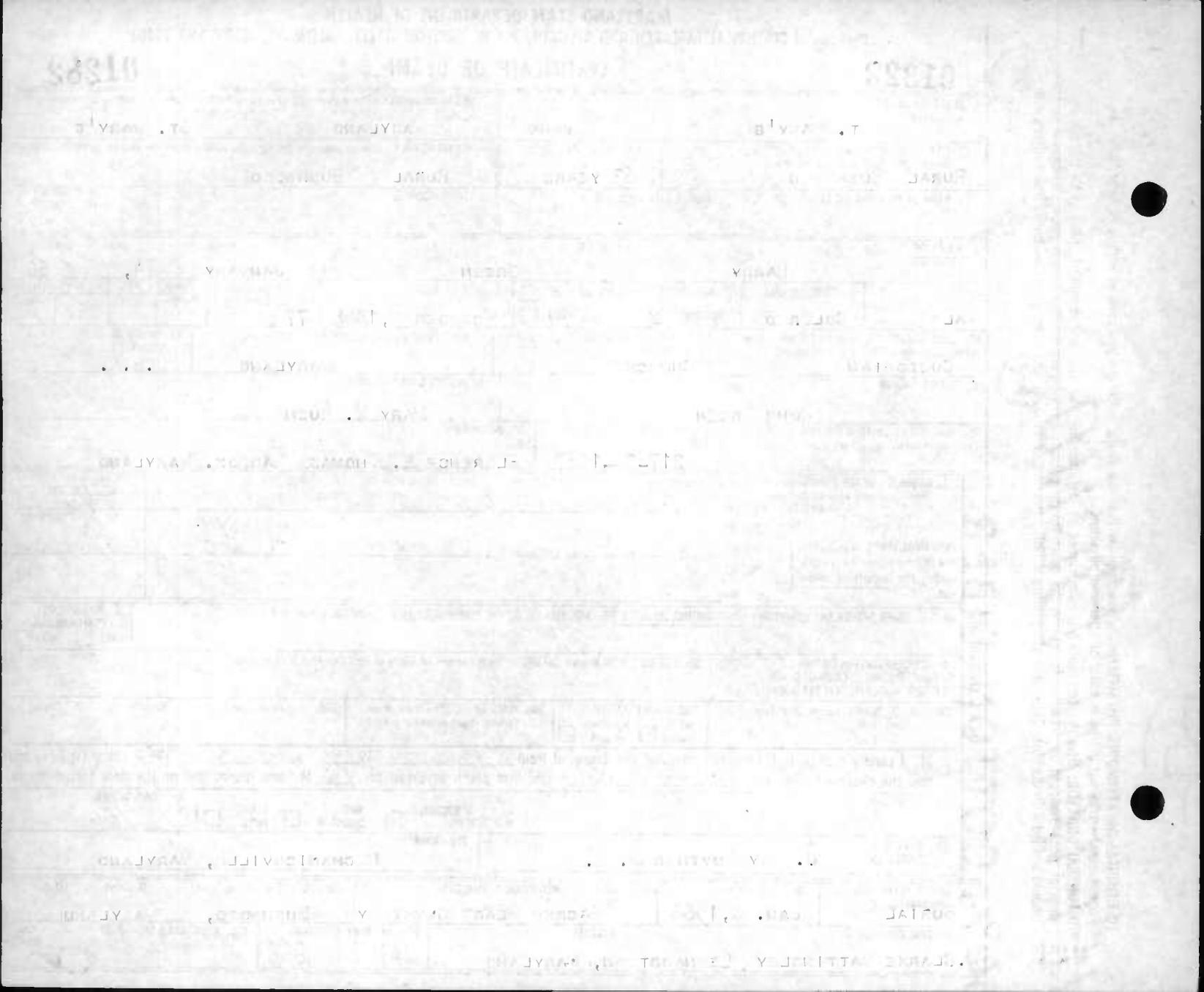
01282

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01322

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BUSHWOOD		c. LENGTH OF STAY IN lb 63 YEARS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) HARRY		First GREEN	Middle GREEN			
S. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>			
8. DATE OF BIRTH OCTOBER 2, 1888		9. AGE (In years last birthday) 77 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10b. KIND OF BUSINESS OR INDUSTRY CHURCH				
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JOHN GREEN		14. MOTHER'S MAIDEN NAME MARY E. BUSH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-30-1067	17. INFORMANT FLORENCE E. THOMAS MADDUX, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis or dissecting aneurysm		INTERVAL BETWEEN ONSET AND DEATH 10 hrs				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerotic CV disease		DUE TO 20 yrs				
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jen	20f. (City or town) Jen	(County) Jen	(State) Jen
21. I certify that (I) (this hospital) attended the deceased from Jen , 19 50 , to Jen 4 , 19 66 , that (I) (we) last saw the deceased alive on Jen 4 19 66 , and that death occurred at Jen M. from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. SIGNATURE Roy Guyther		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1/8/66	
22c. PHYSICIAN'S NAME (Type) J. ROY GUYHER M. D.		22d. ADDRESS MECHANICSVILLE, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 8, 1966	23c. NAME OF CEMETERY OR CREMATORIAL SACRED HEART CEMETERY	23d. LOCATION (City or Town) BUSHWOOD, MARYLAND		(County) (State)
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		ADDRESS		25a. REC'D BY REGISTRAR JAN 13 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY S T. MARYS					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL MECHANICSVILLE c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL MECHANICSVILLE BOX 58 18-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First BEATRICE	Middle MARY	Last HILL	4. DATE OF DEATH JANUARY 1 1966	Month	Day	Year		
5. SEX FEMALE			6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JULY 4, 1900	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months	Days	Hours	IF UNDER 24 HRS Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC			11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME NELSON WILSON			14. MOTHER'S MAIDEN NAME ALICE GRAY								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. N/A			17. INFORMANT GEORGE HILL SAME AS #2			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vasculitis Accident 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vasculitis DUE TO Underlying cause last. (c) 1575 INTERVAL BETWEEN ONSET AND DEATH 6 wks											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov. 1965 to Dec. 1965 , that (I) (we) last saw the deceased alive on Nov. 1965 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE Lewy 22b. DATE SIGNED 1/2/66											
22c. PHYSICIAN'S NAME (Type) Leon W. Berube, M.D.			22d. ADDRESS MECHANICSVILLE, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 1/3/66			23c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPH'S CEMETERY			23d. LOCATION (City, town or county) (State) MORGANZA, MARYLAND		
24. FUNERAL DIRECTOR P.B. ROBINSON			ADDRESS LEONARDTOWN, MARYLAND			25a. REC'D BY REGISTRAR JAN 5 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 20M 1/65											

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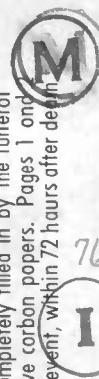
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01324

CERTIFICATE OF DEATH

01284

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN lb 25 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LOVEVILLE 18-1						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First JOHN	Middle L.	Last JENKINS	4. DATE OF DEATH Month JANUARY	Day 30	Year 1966			
S. SEX MALE	6. COLOR OR RACE CLOORED	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH JULY 17, 1907	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Doys 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL SERVICE		10b. KIND OF BUSINESS OR INDUSTRY CSA-920 625		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME XXXXXXXXXXXXXX ANNIE JENKINS			Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT M. JAMES JENKINS MORGANZA, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous DUE TO 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Cancer of Colon DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 10 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Office		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Oct 17, 1965 to Jan 18, 1966 , that (I) (we) last saw the deceased alive on Dec 19, 1965 and that death occurred at M. from causes and on the date stated above.										22b. DATE SIGNED 1/31/66
22a. SIGNATURE J. F. Mossman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/31/66		
22c. PHYSICIAN'S NAME (Type) DAVID MOSSMAN M.D.		22d. ADDRESS MECHANICSVILLE, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Feb. 2, 1966		23c. NAME OF CEMETERY OR CREMATORIAL St. JOSEPH'S CEMETERY		23d. LOCATION (City or Town) (County) (State) MORGANZA, MARYLAND				
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				ADDRESS		25a. REC'D. BY REGISTRAR FEB 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

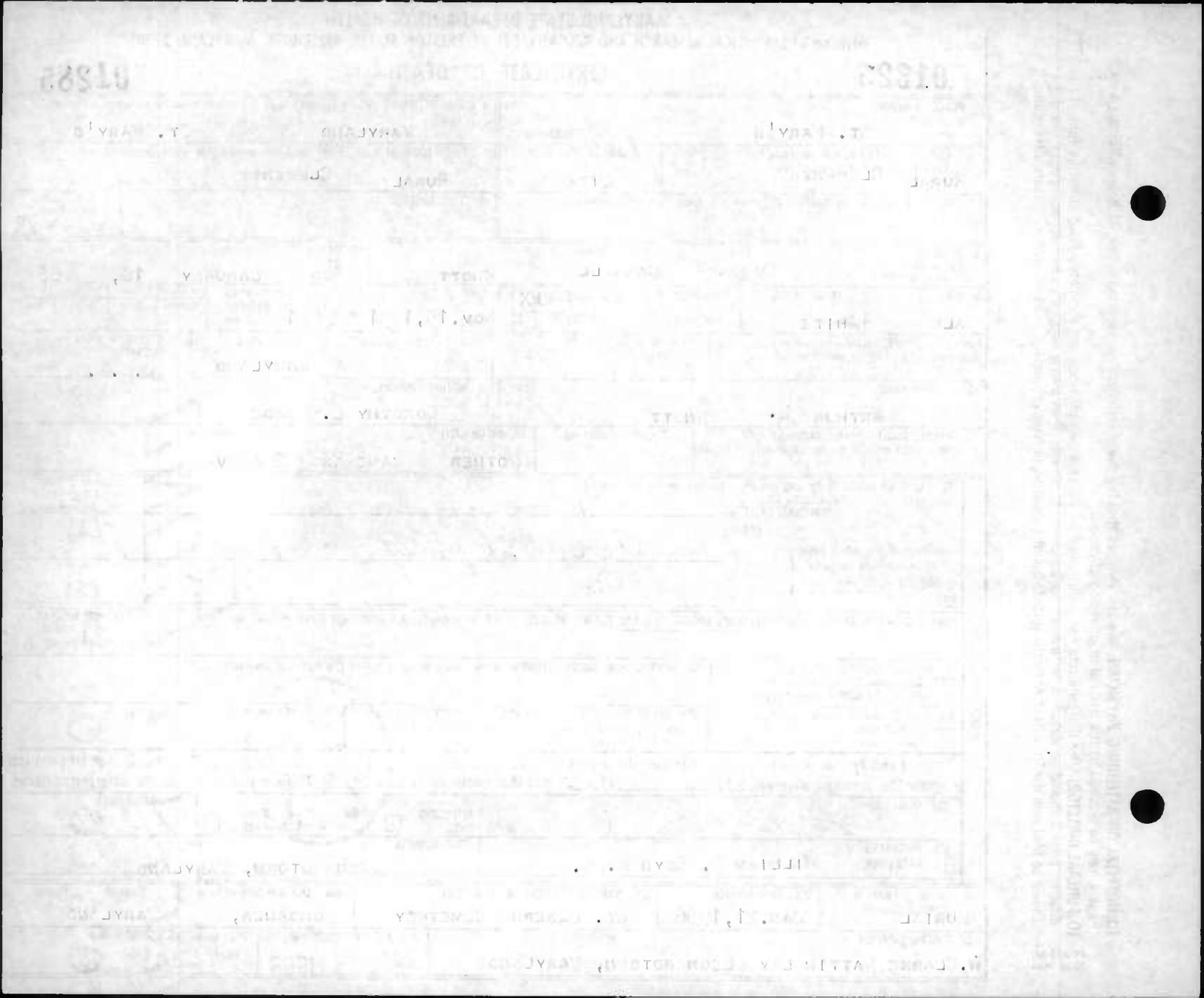
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CERTIFICATE OF DEATH

01285

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ELEMENTS	c. LENGTH OF STAY IN lb LIFE	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ELEMENTS 18-1	d. STREET ADDRESS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EUGENE CARROLL KNOTT		4. DATE OF DEATH JANUARY 18, 1966	Month Day Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years at birthday) 14 yrs.
			IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME ARTHUR L. KNOTT		14. MOTHER'S MAIDEN NAME DOROTHY E. QUADE	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address MOTHER SAME AS # 2 ABOVE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 351X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral palsy DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 3 days 14 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Jan 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Leonardtown, Maryland
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Jan 1966 , to Jan 18, 1966 , that (I) (we) last saw the deceased alive on Jan 1966 , and that death occurred at 430 M. from causes and on the date stated above.			
22a. SIGNATURE WILLIAM D. BOYD M. D.		22b. DATE SIGNED 1/20/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 21, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPHS CEMETERY
23d. LOCATION (City or Town) (County) (State) MORGANZA, MARYLAND		23e. REC'D BY REGISTRAR MN 24 1966	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01326

CERTIFICATE OF DEATH

01286

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b D. O. A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle ALLEN	Last LOFTIS
4. DATE OF DEATH JANUARY 8, 1966	Month Day Year		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 26, 1892
9. AGE (In years last birthday) 73 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER	11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME SAMUEL LOFTIS	14. MOTHER'S MAIDEN NAME BETTY DUNN	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII	
16. SOCIAL SECURITY NO. 579-09-6161	17. INFORMANT MRS ROSA CAREY LOFTIS	Address CALIFORNIA, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct INTERVAL BETWEEN ONSET AND DEATH 4201 DUE TO Conditions, If any, which gave rise to Immediate (b) cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury In Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-1, 1966 to 19 , that (I) (we) last saw the deceased alive on 1-8, 1966 , and that death occurred at 9:50 AM , from the causes and on the date stated above.			
22a. SIGNATURE Juanite Roa M.D.		22b. DATE SIGNED 1-1, 1966	
22c. PHYSICIAN'S NAME (Type) JUANITE ROA M. D.		22d. ADDRESS LEXINGTON PARK, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 11, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND	25a. REC'D BY REGISTRAR JAN 13 1966 25b. REGISTRAR'S SIGNATURE Charles Judge

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10. The following table gives the number of hours per week spent by students in various activities.

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1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		01287	
1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown			c. LENGTH OF STAY IN 1b life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown			d. STREET ADDRESS 18-1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital															
3. NAME OF DECEASED (Type or print)		First Twin II	Middle Baby	Last Boy	Maddox	4. DATE OF DEATH		Month January	Day 7	Year 1966					
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan 6, 1966	9. AGE (In years last birthday) yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? I.S.						
13. FATHER'S NAME Joseph Aloysius Maddox						14. MOTHER'S MAIDEN NAME Mary Alice Stewart									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mary Alice Maddox, Leonardtown, Md.									
no															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Premature												INTERVAL BETWEEN ONSET AND DEATH			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Leonardtown		(County) Maryland		(State) MD		
21. I certify that (I) (this hospital) attended the deceased from 1/7/66 , 19, to 19 , 19, that (I) (we) last saw the deceased alive on 1/7/66 , 19, and that death occurred at M , from the causes and on the date stated above.															
22a. SIGNATURE Leon W. Perube, M.D.						22b. DATE SIGNED JAN/15, 1966									
22c. PHYSICIAN'S NAME (Type) Leon W. Perube						22d. ADDRESS MECHANICSVILLE, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 17, 1966		23c. NAME OF CEMETERY OR CREMATORIAL ST. ALOYSIUS CEMETERY		23d. LOCATION (City, town or county) LEONARDTOWN		(State) MARYLAND							
24. FUNERAL DIRECTOR W. Clarke Mattingley, Leonardtown, Md.						ADDRESS									
						25a. REC'D BY REGISTRAR JAN 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							

CHARTERED ACCOUNTANT

JOHN H. COOPER & CO., LTD. 100,000,000 POUNDS STERLING

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

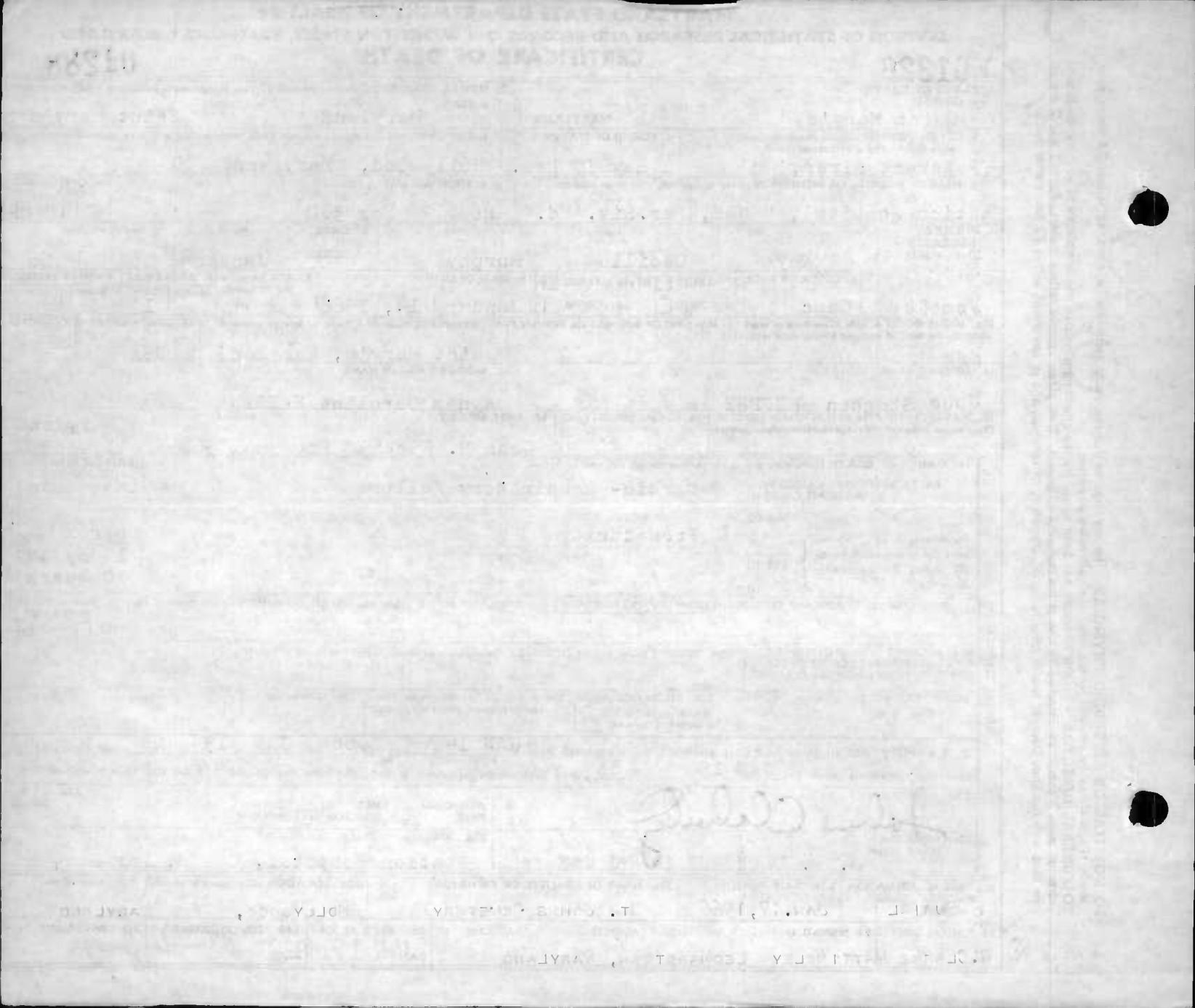
01288

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01328

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY Saint Mary's MARYLAND		a. STATE Maryland b. COUNTY Saint Mary's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Patuxent River, Md		c. LENGTH OF STAY IN 1b 1 day 10 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Station Hospital, USNAS, Pax.Riv. Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kay Cecilia Murphy		First	Middle
Last		4. DATE OF DEATH	Month Day Year
		January 15	19 66
5. SEX Female		6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH January 14, 1966
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) John Stephen MURPHY		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Saint Mary's, Maryland
13. FATHER'S NAME John Stephen MURPHY		14. MOTHER'S MAIDEN NAME Agnes Caroline HAYDEN	12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	17. INFORMANT John S. Murphy Rt#2 Box 36D Hollywood
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 7735		DUE TO Cardio- Respiratory Failure	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Prematurity	
(c)		INTERVAL BETWEEN ONSET AND DEATH approx 1 day and 10 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Station Hospital, USNAS, Pax Riv. Md.
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JAN 14 , 19 66 , to JAN 15 , 19 66 , that (I) (we) last saw the deceased alive on JAN 15 , 19 66 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>John Cloherty</i>		22b. DATE SIGNED JAN 19 1966	
22c. PHYSICIAN'S NAME (Type) J. P. CLOHERTY LT MC USN		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 17, 1966	23c. NAME OF CEMETERY OR CREMATORIUM St. JOHNS CEMETERY
23d. LOCATION (City, town or county) HOLLYWOOD		(State) MARYLAND	
24 FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		ADDRESS	25a. REC'D BY REGISTRAR JAN 19 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys													
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) St. Inigoes				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) St. Inigoes													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rural				d. STREET ADDRESS Rural													
3. NAME OF DECEASED (Type or print) JOHN WOOD OLIVER				First		Middle		Last		4. DATE OF DEATH January 3 1966	Month	Day	Year				
5. SEX male				6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12/5/1886		9. AGE (in years last birthday) 79 yrs.	IF UNDER 1 YEAR <input type="checkbox"/>	IF UNDER 24 HRS <input type="checkbox"/>	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Builder)				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) St. Marys Co., Maryland								12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Edward T. Oliver				14. MOTHER'S MAIDEN NAME Sarah Wise								Address 3902 Volta Ave.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 577 01 5097		17. INFORMANT Margaret F. West		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Circulation collapse INTERVAL BETWEEN Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Myocardial Infarction months (c) DUE TO Coronary artery Disease months									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hemocarcinoma of prostate, bone metastasis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MEDICAL CERTIFICATION		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Jan 3, 1966		(County) Great Mills, Maryland		(State) 1/3/66					
21. I certify that (I) (this hospital) attended the deceased from Jan 3, 1966 to Jan 3, 1966 , that (I) (we) last saw the deceased alive on 1966 , and that death occurred at 10A M, from the causes and on the date stated above.		22a. SIGNATURE J. Patrick Jarboe, M.D.		22b. DATE SIGNED 1/3/66		22c. PHYSICIAN'S NAME (Type) J. Patrick Jarboe, M.D.		22d. ADDRESS Great Mills, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/5/66		23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cem.		23d. LOCATION (City, town or county) Washington, D.C.											
24. FUNERAL DIRECTOR P.B. Robinson		ADDRESS P.B. Robinson - Leonardtown, Maryland		25a. REC'D BY REGISTRAR JAN 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge											

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10. The following table shows the number of hours worked by each employee.

10. *Leucosia* (L.) *leucostoma* (L.) *leucostoma* (L.) *leucostoma* (L.)

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

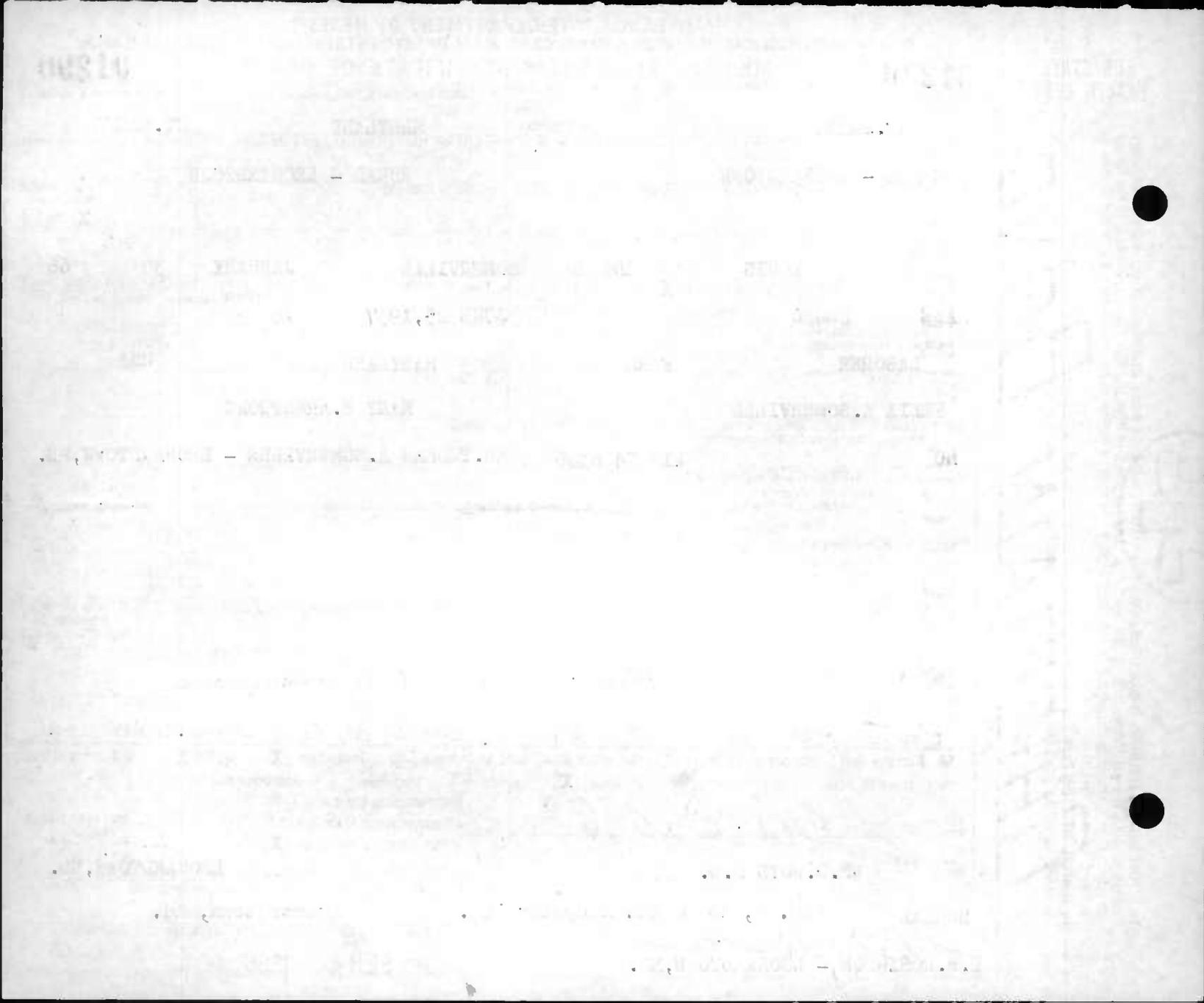
01290

01330

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - LEONARDTOWN		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS RURAL - LEONARDTOWN 18-1	
3. NAME OF DECEASED (Type or print) LOUIS EDWARD SOMERVILLE		4. DATE OF DEATH Month JANUARY Day 30 Year 1966	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 25, 1937
9. AGE (In years last birthday) Months 28 yrs. Days 0 Hours 0 Min. 0	10. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FELIX A. SOMERVILLE	14. MOTHER'S MAIDEN NAME MARY E. ARMSTRONG	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 218 34 6306
17. INFORMANT MR. THOMAS A. SOMERVILLE - LEONARDTOWN, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9325 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ causa (a), stating the underlying cause last. (c) _____	
		INTERVAL BETWEEN ONSET AND DEATH inmed	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20. MEDICAL CERTIFICATION 2da. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell in snow while walking home	20c. TIME OF INJURY Month, Day, Year Hour 6:00 p.m. Month 1-30 Day 1966	2dd. INJURY OCCURRED at work <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, officabldg., etc.) PVT. RD BRETON BAY FARM - LEONARDTOWN
20f. (City or town) MD	20g. (County) Leonardtown	20h. (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and In my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22. DATE SIGNED 2/4/66			
EXAMINER'S NAME (Type) W.M.D. BOYD M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Feb. 7, 1966	23c. NAME OF CEMETERY OR CREMATORIUM St. Aloysius Cem.	23d. LOCATION (City, town or county) (State) Leonardtown, Md.
24. FUNERAL DIRECTOR P.B. Robinson	ADDRESS LEONARDTOWN, MD.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
VR AISM (5) 5M 1/65		DATE FEB 7 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

01331

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01291

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN D.O.A.		c. LENGTH OF STAY IN 1b RURAL COLTON POINT 18-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HENRY MILES THOMAS		First Middle Last	4. DATE OF DEATH Month JANUARY 30, 1966
S. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 30, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 71 yrs.
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country) MARYLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT JOSEPHINE L. THOMAS 121 MERCURY STREET
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) } DUE TO (c) }		PETERSBURG, VIRGINIA INTERVAL BETWEEN ONSET AND DEATH coronary embolism arteriosclerosis HD 10 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William D. Boyd</i>	M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) WILLIAM D. BOYD M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) 1/2/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF FEB. 3, 1966	23c. NAME OF CEMETERY OR CREMATORIUM ALL SAINTS CHURCH CEMETERY	23d. LOCATION (City or Town) (County) (State) OAKLEY, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND	ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 4 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death Certificate be executed within 24 hours.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film G378 7/1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01292

1. PLACE OF DEATH a. COUNTY <i>Saint Marys Hospital</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Valley Lee Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saint Marys County</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saint Marys County</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Saint Marys Hospital</i>		d. STREET ADDRESS <i>18-1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Ulysses</i>	Middle <i>James</i>	Last <i>Thompson</i>
4. DATE OF DEATH	Month <i>1</i>	Day <i>16</i>	Year <i>1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>1-2-03</i>
9. AGE (In years last birthday) <i>63 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (County & State, or foreign country) <i>Valley Lee Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>United States</i>
13. FATHER'S NAME <i>Edmund Thompson</i>	14. MOTHER'S MAIDEN NAME <i>Emma Miller</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.	17. INFORMANT <i>Marshall Thompson</i> Address <i>5559 E. Ellevon Ave</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarct</i> OUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Pneumonitis. hypertensive heart disease</i> (b) OUE TO (c) Hemoptysis etio not known	
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1-4</i> , 19 <i>66</i> , to <i>1-16</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1-16</i> 19 <i>66</i> , and that death occurred at <i>710 M</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>J. C. Rose M.D.</i>		22b. DATE SIGNED <i>1-16-66</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 1-14-66</i>		23b. DATE THEREOF <i>1-14-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Mt Auburn</i>
24. FUNERAL DIRECTOR <i>Althea L. McCrum</i>		25a. REC'D BY REGISTRAR <i>JAN 17 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>

